DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155171	B. WING		11/29/2011
NAME OF I	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF I	ROVIDER OR SOLI EIE	IX.	1285 W	JEFFERSON ST	
FRANKL	IN MEADOWS		FRANK	LIN, IN46131	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	Tricin init	In a salination of	F0000	The avertion and	
	This visit was for Investigation of		F0000	The creation and	
	Complaints IN0	00099148 and		submission of this Plan	OT
	IN00099246.			Correction does not	la
				constitute an admission	by
	•	0099148 Substantiated.		this provider of any	
		eficiencies related to the		conclusion set forth in the	
	allegations are o	cited at F282 and F323.		statement of deficiencie	es or
				of any violation of	
	Complaint IN00	0099246 Substantiated.		regulation.	
	No deficiencies	related to the allegations			
	are cited.			This provider respectful	
				requests that the 2567	
	Unrelated defici	iencies cited		of Correction be consider	ered
				the Letter of Credible	
	Survey date:			Allegation and requests	
	November 28 &	2 29. 2011		Desk Review in lieu of a	
		,		Post Survey Revisit on	
	Facility number	000087		after December 29, 201	1.
	Provider number				
	AIM number: 1				
		10020,000			
	Survey team:				
	Mary Jane G. F.	ischer RN			
	Waiy Jane G. 1	isolici Kiv			
	Census bed type	٠.			
	SNF/NF: 106	J.			
	Total: 106				
	101.100				
	Census payor ty	ne.			
	Medicare: 11	po.			
	Medicaid: 74				
	Other: 21				
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ3J11

Facility ID:

000087

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155171	B. WING		11/29/2011
	ROVIDER OR SUPPLIER		1285 W	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST LIN, IN46131	
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F0282 SS=D	findings cited in 16.2. Quality review condenses are cond	ided or arranged by the povided by qualified persons in each resident's written review and interview, the ensure a physician's order alarm was followed for 1 viewed for physician uple of 5. [Resident "A"]. : esident "A" was reviewed 0:05 a.m. Diagnoses e not limited to cile, dementia, ercranial hemorrhage, inary tract infection.	F0282	F 282 SERVICES PROVIDED BY A QUALIFIED PERSON/P CARE PLAN It is the practice of this facility to ensure service provided or arranged by facility are provided by qualified persons in accordance with each resident's written plan or care. What corrective action will be accomplished for those residents found to have been affected is the deficient practice	the f (s) or

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155171 11/29/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST FRANKLIN MEADOWS FRANKLIN, IN46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the resident was totally dependent for bed Resident (A) no longer resides in this facility. mobility and required two + staff persons for repositioning needs. Although the resident did not have a fall prior to How other residents having the potential to be admission, the assessment indicated affected by the same "resident is at risk for falls due to deficient practice will be gait/balance, medications, incontinence, new admission and confusion. Res. identified and what corrective action(s) will [resident] has had recent CVA [cerebral be vascular accident - has a history of taken dementia and poor cognitive skills and safety awareness. Res. is non ambulatory Residents with an order for at this time, res. is transferred with a bed sensor alarm have assistance. Fall interventions include the potential to be affected pressure alarm in bed, non skid footies or by the alleged deficient shoes when up, half noodle under lateral practice. The edge of mattress, half side rails in grab bar DNS/designee will complete position to assist with bed mobility." an audit by 12/12/11 to ensure all residents that A physician order, dated 06-21-11, have a physicians order for instructed the nursing staff to implement a bed sensor alarm have "bed sensor alarm, check for placement the bed sensor alarm in every shift, non skid footies/shoes when place. The Staff up." Development Coordinator/designee will Physician orders, dated 06-22-11, in-service nursing staff by included "landing strip next to bed, 1/2 12/20/11. Licensed nurses noodle to right lateral side of bed under will be educated on mattress secondary to decreased safety following physicians orders awareness, increased fall risk." to ensure interventions are in place, this will include A review of the "Event Report," dated bed sensor alarms. 07-03-11 at 10:25 p.m., indicated the Licensed staff also resident had an unwitnessed fall, and was

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/29/2011	
	ROVIDER OR SUPPLIER		1285 W	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST LIN, IN46131		
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TAG	found lying on be adjacent to the be into place to prevent pressure pad alar. The "Event Report detailed the follow on pad on floor reassessed for pain Nursing neuroch limits], physician [information] on [family member] member] seemed event after explassive measures which pressure pad alar bed." A subsequent no 10:24 a.m., indicate include placing current intervent alarm in bed, nor noodle to right lassification, landing On 11-29-11 at 1 Nurse Consultant the "Event Report of the pressure properties of the position, landing the "Event Report of the pressure properties of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle to right lassification, landing the "Event Report of the pressure pad alarm in bed, nor noodle t	ack on landing pad ed. "Interventions put vent another fall - rm applied." ort," progress notes wing: "Resident found next to bed - resident or injury both negative. ecks wnl [within normal in faxed infor. event, spoke with on phone [family I non problematic with ination [sic] of reactive	TAG	responsible for providing immediate intervention to is not already a part of the resident care plan. Unlicensed nursing staff educated on following the resident assignment she to ensure all intervention are in place. What measures will be put into place or what systemic changes will made to ensure that the deficient practice does not recur The Staff Development Coordinator/designee win-service nursing staff to 12/20/11. Licensed nursion will be educated on following physicians ord to ensure interventions a in place, this will include bed sensor alarms. Licensed staff also responsible for providing immediate intervention to is not already a part of the resident care plan. Unlicensed nursing staff.	that the fine eet eet ees ers ers ere ers ere ers ere ers ere er ers ere ere	
	bed sensor was a	pplied as a "reactive" e resident had fallen.		educated on following th		

AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:					
			A. BUII	DING	00	COMPL	
		155171	B. WIN			11/29/20	011
NAME OF DE	OMBER OF GUIDNIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER			1285 W	JEFFERSON ST		
	N MEADOWS			FRANKI	LIN, IN46131		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					resident assignment she		
During a subsequent interview on				to ensure all intervention			
	11-29-11 at 2:00	p.m., the Director of			are in place. Post tests	will	
	Nurses indicated	she was unaware if the			be administered to ensu	ıre	
	bed sensor alarm	had been implemented.			understanding of in-serv	/ice	
		-			provided. Unit		
	Although the orig	ginal physician orders			managers/charge nurse	will	
		s included the use of a			make rounds every shift		
		while the resident was in			ensure that proper fall		
	-				prevention interventions	are	
		staff failed to implement			in place. These rounds		
		ice to alert the nursing			be documented and	····	
		d ambulation or transfer			reviewed daily. Any		
	of the resident.				interventions not in plac	_ ا	
					-		
	This Federal tag	relates to Complaint			will immediately be		
	IN00099148.				corrected by unit		
					manager/charge nurse.		
	3.1-35(g)(2)				Staff not ensuring fall		
					interventions in place w	ill be	
					disciplined accordingly.		
					How the corrective		
					action(s) will be		
					• •		
					monitored to ensure th	le	
					deficient		
					practice will not recur,		
					i.e., what quality		
					assurance program wi	II	
					be put		
					into place; and by wha	t	
					date the systemic		
					changes will be		
					completed		
					, p		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155171	A. BUIL B. WING			11/29/2	011
			В. WII ((_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				JEFFERSON ST		
FRANKLI	N MEADOWS		FRANKLIN, IN46131				
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					A CQI tool will be utilize	d by	
					the SDC/designee to		
					monitor the proper use of	of	
					bed sensor alarms week	кly	
				x4, bi-weekly x2, and			
					monthly thereafter until		
					compliance has reached	1	
					100% for 90 days. The	^	
					CQIs will be reviewed		
					monthly by the CQI		
					Committee. If at any tim	_	
					the threshold falls below		
					95% an action plan will l		
					initiated. Non-compliand		
					this practice will result in	1	
					education and/or		
					disciplinary action of the	:	
					responsible employee.		
F0323	•	nsure that the resident					
SS=D		ins as free of accident					
		sible; and each resident supervision and assistance					
	devices to prevent	•					
	•	review and interview, the	FO'	323	F 323 FREE OF		12/29/2011
	facility failed to		10.		ACCIDENT		12/2//2011
	•					ON/	
	-	of assistive devices, in			HAZARDS/SUPERVISION	JN/	
		ent was assessed as a fall			DEVICES		
	risk and interven						
		ursing staff failed to			It is the practice of this		
	-	mentation of an alarm to			provider to ensure that a		
	alert the nursing	staff of unassisted			alleged violations involv	ing	
	ambulation/unsa	fe movement, which			free of		
resulted in a fall for 1 of 4 resident's				accident/hazards/superv	/isio		
		s in a sample of 5.			n/devices are provided		
	[Resident "A"].	on a bumple of J.			in accordance with State	e l	
	[Resident A].						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ3J11 Facility ID:

000087

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171			LDING	nstruction 00	(X3) DATE SURVEY COMPLETED 11/29/2011	
	PROVIDER OR SUPPLIER	1	<i>5.</i> (12.)	STREET A	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST LIN, IN46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Findings include	:			and Federal law through established procedures.	
	on 11-28-11 at 1 included but wer Clostridium diffi hypertension, int and history of ur	cile, dementia, ercranial hemorrhage, inary tract infection. remained current at the			What corrective action will be accomplished for those residents found to have been affected to the deficient practice. Resident (A) no longer resides in this facility.	or
	Set Assessment, the resident was mobility and req for repositioning resident did not ladmission, the as "resident is at ris gait/balance, menew admission a [resident] has ha vascular accident dementia and posafety awareness at this time, resassistance. Fall pressure alarm in shoes when up, h	sident's Minimum Data dated 07-02-11, indicated totally dependent for bed uired two + staff persons needs. Although the nave a fall prior to ssessment indicated k for falls due to dications, incontinence, nd confusion. Res. d recent CVA [cerebral t - has a history of or cognitive skills and a. Res. is non ambulatory is transferred with interventions include h bed, non skid footies or half noodle under lateral half side rails in grab bar			How other residents having the potential to affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents have the potential to be affected by this alleged deficient practice. An in-service was be conducted for all numbersonnel by 12/20/11 by the facility SDC/designer regarding fall prevention implementation of assist devices such as bed series.	by vill sing by ee n, tive
	•	with bed mobility." an of care, updated on			alarms, checking placer and function of assistive	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155171 11/29/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST FRANKLIN MEADOWS FRANKLIN, IN46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 07-06-11, indicated "Fall risk related to devices every shift, and utilization of resident care gait/balance, CVA, medications and sheets by the cna to ensure diagnoses." Interventions included Low all fall interventions are in bed, encourage to use call light, fall risk place. assessment, provide appropriate assistive What measures will be devices such as pressure alarms in bed, put into place or what landing strips on floor next to bed, half noodle under lateral edge of mattress, non systemic changes will be made to ensure that the skid footies or shoes when up." deficient practice does not recur Review of the Physical Therapy initial assessment, dated as SOC [Start of Care] An in-service will be 06-21-11, indicated "Precautions: fall conducted for all nursing risk." personnel by 12/20/11 by the facility SDC/designee The Occupational Therapy initial regarding fall prevention, assessment, dated as SOC 06-22-11, implementation of assistive indicated "Precautions: "fall risk." devices such as bed sensor alarms, checking placement A physician order, dated 06-21-11, and function of assistive instructed the nursing staff to implement devices every shift, and "bed sensor alarm, check for placement utilization of resident care every shift, non skid footies/shoes when sheets by the cna to ensure up." all fall interventions are in place. The DNS/designee Physician orders, dated 06-22-11, will complete an audit by included "landing strip next to bed, 1/2 12/12/11 to ensure all noodle to right lateral side of bed under residents that have a mattress secondary to decreased safety physicians order for a bed awareness, increased fall risk." sensor alarm have the bed sensor alarm in place. Unit A review of the "Event Report," dated managers/charge nurse will 07-03-11 at 10:25 p.m., indicated the make rounds every shift to resident had an unwitnessed fall, and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155171 11/29/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1285 W JEFFERSON ST FRANKLIN MEADOWS FRANKLIN, IN46131 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE found lying on back on landing pad ensure that proper fall adjacent to the bed. "Interventions put prevention interventions are in place. These rounds will into place to prevent another fall be documented and pressure pad alarm applied." reviewed daily. Any interventions not in place The "Event Report," progress notes will immediately be detailed the following: "Resident found corrected by unit on pad on floor next to bed - resident manager/charge nurse. assessed for pain or injury both negative. Staff not ensuring fall Nursing neurochecks wnl [within normal interventions in place will be limits], physician faxed infor. disciplined accordingly. [information] on event, spoke with [family member] on phone [family member] seemed non problematic with How the corrective event after explaination [sic] of reactive action(s) will be measures which include placing a monitored to ensure the pressure pad alarm under resident while in deficient practice will not bed." recur, i.e., what quality assurance program will A subsequent notation, dated 07-05-11 at be put into place; and by 10:24 a.m., indicated "New intervention what date the systemic to include placing low bed. Resident's changes will be current interventions include pressure completed: alarm in bed, non skids when up, 1/2 noodle to right lateral side of bed under A fall management CQI mattress, 1/2 side rails in grab bar audit tool will be completed position, landing strip next to bed." once weekly x4, bi-weekly x2, and then monthly Review of the Treatment Order Record," thereafter by a facility Unit for the month of July 2011 lacked Manager/designee. The fall documentation the assistive device bed management CQIs will be sensor alarm had been checked for reviewed monthly by the placement and function on July 2, the 3 -CQI Committee 90 days 11 shift, and July 3rd - 11-7 shift as well

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	included a staff recircled on July 3. The reverse side record lacked an circled entry. On 11-29-11 at 1. Nurse Consultan the "Event Report order, and then it bed sensor was a measure after the During a subsequence of the sensor alarm. Although the original interventions pressure alarm wheely, the nursing the assistive devistaff of unassiste of the resident.	The documentation nembers "initial" that was rd for the 3 - 11 shift. of the treatment order explanation of the 1:30 a.m., the Corporate temployee #5, reviewed rt" and the physician indicated it appeared the pplied as a "reactive" exception resident had fallen. Inent interview on p.m., the Director of she was unaware if the had been implemented. Inginal physician orders is included the use of a rehile the resident was in staff failed to implement the total alert the nursing diambulation or transfer.		after which the CQI will re-evaluate the continued need for the audit. If at any time is threshold falls below an action plan will be initiated. Non-complethis practice will restricted education and/or disciplinary action of responsible employed.	he the 795% e iance in ult in	

Facility ID:

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2011	
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F0441 SS=D	Infection Control F a safe, sanitary ar and to help prever transmission of dis (a) Infection Contr The facility must e Program under wh (1) Investigates, coinfections in the fa (2) Decides what p isolation, should b resident; and (3) Maintains a recorrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease. (3) The facility mu hands after each of	establish an Infection Control nich it - controls, and prevents cility; crocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	Personnel must ha	andle, store, process and o as to prevent the spread of					
	facility failed to documentation o transmission con	review and interview, the ensure the accurate f a communicable dition, in that when a	FO)441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS		12/29/2011
		ntified with head lice, the			It is the practice of this	–	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	EQ3J11	Facility I	D: 000087 If continuation s	heet Pac	ge 11 of 19

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155171	B. WIN			11/29/20	/ 1 1
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	IN MEADOWO				JEFFERSON ST		
	IN MEADOWS			<u> </u>	_IN, IN46131		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION	丁	(X5)
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TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG		,d	DATE
		coordinator failed to			facility that an established		
		mation in the monthly			Infection Control Progra	I	
		surveillance data for 1 of			maintained and designe	I	
		wed for head lice in a			provide a safe, sanitary	I	
	_	1 of 1 infection control			comfortable environmen	IL	
	surveillance prog	grams reviewed.	1		and to help prevent the		
	[Resident "E"].				development and		
					transmission		
	Findings include	:			of disease and infection	.	
	The record for R	esident "E" was reviewed			What corrective action	(s)	
	on 11-29-11 at 1:50 p.m. Diagnoses		1		will be accomplished for		
		re not limited to multiple			those residents found		
		sive disorder, and			to have been affected b	by	
	-	liagnoses remained			the deficient practice	-	
		ne of the record review.			F 12003		
	current at the tim	ic of the record leview.			Resident (E) was added	to	
	Dovier C "F	wont Dangert II day . 1			the infection control		
		vent Report," dated			surveillance data for the	1	
	•	ted "Infection Control			month of October 2011.		
	1	rt. Other signs and					
		bugs. Medication					
		hampoo x's 1 now again			How other residents		
	1	: Hair tx. [treatment]			having the potential to	be	
		[edical Doctor] order.			affected by the same	~~	
		ol. [tolerated] well.			deficient practice will b) <u>e</u>	
		sonal items treated as			identified and what	,-	
	well. Nits and bu	ugs removed by hand."				,	
					corrective action(s) wil	•	
	Interview on 11-	29-11 at 1:30 p.m., the			be taken		
	Director of Nurse	es verified resident "E"			taken		
	was identified wi	ith head lice, and			All rapidants been "		
	subsequently trea	*			All residents have the		
					potential to be affected to	υy	
	The facility "Cor	nditions & Infections			the alleged deficient		
FORM CMS-2	2567(02-99) Previous Version		EQ3J11	Facility II	D: 000087 If continuation sh	neet Pag	e 12 of 19

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155171		LDING	00	11/29/2	
		100171	B. WIN		DDDEGG GUTY GTATE TID GODE	11/25/2	011
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST		
FRANKL	IN MEADOWS				LIN, IN46131		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		mmendations," reviewed			practice. The infection		
		:10 p.m., indicated "Lice:			control coordinator was		
	•	is) - contact isolation.			educated by the Directo	r ot	
	Follow physician orders for shampoo				Nursing Services on		
	treatment - use gowns & gloves during				11/30/11 to include any		
	treatment."				occurrence of head lice	on	
					the monthly infection	_	
	Review of the In				control surveillance data	1.	
		a on 11-28-11 at 11:00					
	,	nth of October 2011					
	lacked information related to the resident and the treatment received for head lice.				14.11 d		
					What measures will be		
					put into place or what		
	Interview on 11-	29-11 at 2:30 p.m., with			systemic changes will		
	the Regional Dir	rector of Nursing Services			made to ensure that th	_	
	indicated the sur	veillance data should			deficient practice does	i	
	have included th	e information related to			not recur		
	the resident iden	tified with head lice.					
					The infection control		
	3.1-18(b)(1)(A)				coordinator will utilize th		
					daily surveillance log for		
					infections. All infections	are	
					reviewed by the		
					interdisciplinary team		
					Monday through Friday,		
					excluding holidays.	atar	
					Infection control coordin		
					compiles information on		
					the infection control trac	•	
					map at the end of every month. The infection co		
					coordinator was educate		
					by the Director of Nursir		
					Services on 11/30/11 to	•	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2011 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155171	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 11/29/2011		
	ROVIDER OR SUPPLIER N MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN46131				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
			include any occurrence head lice on the month infection control surveillance data.			
			How the corrective action(s) will be monitored to ensure to deficient practice will not recursive, what quality assurance program who be put into place; and by who date the systemic changes will be completed The daily surveillance investigation log and fatracking map will be reviewed monthly by the CQI committee to ensure compliance with all infections identified, including head lice. Non-compliance in this practice will result in education and/or	rill at acility ne ure		
F9999			disciplinary action of the responsible employee.			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155171	B. WIN	G		11/29/2011	
	PROVIDER OR SUPPLIER	2	•	1285 W	ADDRESS, CITY, STATE, ZIP CODE Z JEFFERSON ST LIN, IN46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPL	
	3.1-13 ADMINI MANAGEMEN (g) The Admini the overall mana shall not function supervisor, for enursing or food at the same hours. the administrator limited to, the form (1) Immediately telephone, follow within twenty-form occurrences that welfare, safety, or residents, includ (D) major accidents. This State rule we by: Based on observer record review, the immediately not incident, in that resident fell from bruising, lacerate the division by the written notice we hours, of the universidents review.	strator is responsible for gement of the facility but as a departmental example, director of service supervisor, during The responsibilities of a shall include, but are not allowing: informing the division by wed by written notice our (24) hours, of unusual directly threaten the for health of the resident or ing but not limited to any: ent. The responsibilities of a shall include, but are not allowing: informing the division by wed by written notice our (24) hours, of unusual directly threaten the for health of the resident or ing but not limited to any: ent. The strator is responsible for a shall include, but are not allowing. Informing the division by wed by any and a fractured nose, and to immediately inform the lephone, followed by a sithin twenty-four (24) and occurrence for 1 of 4 and for falls in a sample of		999	F 9999 FINAL OBSERVATION It is the policy of this facility report unusual occurrences to directly affect the welfare, say or health of the resident or residents, including but not list to major accidents. What corrective action(s) will be accomplished for those residents foundto have been affected by the deficient practice. The Executive Directly and Director of Nursing Service will be re-educated on the Instate Regulations related to reporting unusual occurrence our Corporate Clinical Nurse Specialist by 12/16/11. The other residents having the potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken. Unu occurrences will be reported State and Federal Guidelines Each unusual occurrence wireported to the Clinical Nurse Specialist to ensure proper reporting occurs. What measures will be put into por what systemic changes where the deficient practice does not recur. The unusual occurrence reporting policy has been reviewed by the Executive Director and Director of Nursing Services. The Executive Director and Director of Nursing Services and Direct	n ctor ices diana es by How he be ve sual per s. I be e e e e e e e e e e e e e e e e e	0/2011
FURM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	EQ3J11	Facility 1	ID: 000087 If continuation s	neet Page 15 of	19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	A. BUILDING 00 C		(X3) DATE : COMPL 11/29/2	ETED		
		100171	B. WIN		DDRESS, CITY, STATE, ZIP CODE	11/23/2	V 1 1	
NAME OF PROVIDER OR SUPPLIER			1285 W JEFFERSON ST					
FRANKLIN MEADOWS			FRANKLIN, IN46131					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	on 11-28-11 at 1 included but wer hypertension, dia history of hip reg diagnoses remain the record review. The resident's M Assessment, date resident was sever and required extestaff members for mobility. During an observed seated in a Broda observed with a 11-28-11 at 9:15 Nurse employee fell from bed and nose." The Licerindicated the resident." Review of an "E 11-12-11 at 3:43 following:	esident "C" was reviewed 1:10 a.m. Diagnoses re not limited to dementia, abetes mellitus and a placement surgery. These ned current at the time of			occurrences to ensure timely reporting. Unusual occurrence will be reported to the appropagencies within 24-hours. The Executive Director and DNS be re-educated on the proper policy and procedure regarding unusual occurrences for Residents. How the correct action(s) will be monitored ensure the deficient practice will not recur, i.e., what quassurance program will be put into place; and by what the systemic changes will be completed. An abuse prohib and investigation CQI tool with completed weekly x4 and monitors will be reviewed month the CQI Committee for compliance and determine a need for further action and/or review. If at any time the threshold falls below 100% a action plan will be initiated.	ees oriate e will r ng ive to e ition il be onthly The ly by		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155171		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2011			
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN46131					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE		
	outside door at 2 resident moaning on floor face down lacerated forehead swollen and red. Nurses] notified Sent to hospital with the had a "laceration the nose to forehead to bridge of nose deformity - unwith the physician properties of the physician properties. The Interdisciplication of the control of the control of the report to the "incident 11-12-State Agency on p.m." Review on 11-29 facility "Risk Mainter and red over the resident of the report to the "incident 11-12-State Agency on p.m."	er indicated the resident about 1 inch wide above ead. Laceration 1/2 inch with swelling and itnessed fall." rogress notes, dated ted the resident had a elated to the fall. mary notation, dated ted the resident received head and 3 to nose." onfirmation notification of State Agency indicated 11" and "reported to the 11-16-11 at 17:59 [5:59] o-11 at 11:40 a.m., of the anagement - Resident and Occurrences," undated,						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	A. BUI	BUILDING 00		COMPL	COMPLETED 11/29/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					JEFFERSON ST			
FRANKLIN MEADOWS				FRANK	LIN, IN46131			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
TAG		nusual Occurrence/Event	+	TAG	DET CELL (C.)		DATE	
	[underscored]"	nusual Occurrence/Event						
	1	eurrence/event is defined						
		g not consistent with the						
		n of the nursing facility,						
	which may have	caused or may have the						
	potential for cau	sing injury to residents,						
	visitors, or loss of	or damage of property."						
	IIG	F1 1.1 4 10						
	"Serious events	[bold type]" fall into one or both of						
		1.) Occurrences that						
	_	t or visitor injuries and/or						
		ccurrences that are likely						
	· · · · · · · · · · · · · · · · · · ·	•						
	to result in claims loss. Serious events are categorized into two groups that designate							
	to whom the events are to be reported."							
	to whom the eve	into are to be reported.						
	"A. Events that	are required to be						
	reported to the Director of Operations, DNS [Director of Nursing Services] specialist, and Director of Clinical Services and ISDH [Indiana State Department of Health]. These events must be reported to the ISDH within 24 hours of occurrence and followed by a							
	_	ithin 5 days of the						
	occurrence."							
	"6. SIGNIFICA	NT INJURIES -						
	Examples, but n	ot all inclusive:						
		d while a resident was						
	physically restrained, large areas of							
	contusions (greater than 10 cm), large							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171					E SURVEY LETED 2011			
NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN46131					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
		-						
	p.m., the Directo resident had a RC believed the resident the mattress and addition the Director she failed to immediate the because incident happened unwitnessed, but	r on 11-29-11 at 3:00 r of Nurses indicated the DHO mattress and dent slid from the edge of onto the floor. In ctor of Nurses indicated nediately report the she was "aware" how the d even though it was later due to the extent of rted the incident to the						

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